Florida

DRIVER LICENSE

9 CLASS E

4d DLN C436-620-57-967-0

1 CALDERON MEDINA
2 NELLY
8 15646 SW 40TH ST
MIRAMAR, FL 33027-4806

3 DOB 12/27/1957 15 SEX F
4b EXP 12/27/2025 16 HGT 5'-04"
12 REST A 9a END NONE

DONOR

SAFE DRIVER

4a ISS 06/20/2017

5DD S051911050501

REPLACED 11/05/2019

Operation of a motor vehicle constitutes consent to any sobriety test required by law.

RAPID RATER

Client Data

Display
QoL Flex Term
State
Florida
Gender
Female
Age
64
Face
250,000
Mode
Annual
Flat Extra
0
Table Rating
None
Term to Retirement
Age 62 N/A
Age 65 N/A
Age 67 N/A
Age 70 N/A

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QoL Flex Term Rapid Rater

Annual Premiums

Product	Preferred Plus	Preferred Non-Tobacco	Standard Plus	Standard Non-Tobacco	Preferred Tobacco	Standard Tobacco
10	$993.93	$1,076.43	$1,203.88	$1,454.58	$3,059.18	$4,011.70
15	$1,268.95	$1,478.68	$1,698.68	$1,954.80	$3,843.73	$5,258.98
16	$1,430.33	$1,636.38	$1,869.33	$2,161.18	$4,208.00	$5,592.75
17	$1,559.43	$1,762.50	$2,005.85	$2,326.28	$4,480.30	$5,859.75
18	$1,681.43	$1,888.65	$2,142.35	$2,491.35	$4,752.58	$6,115.88
19	$1,766.63	$2,014.83	$2,278.88	$2,656.45	$5,024.85	$6,325.20
20	$1,830.53	$2,109.43	$2,381.28	$2,780.25	$5,229.08	$6,483.70
21	$2,198.38	$2,519.85	$2,789.30	$3,303.88	N/A	N/A
22	$2,480.53	$2,848.20	$3,115.68	$3,722.80	N/A	N/A
23	$2,732.15	$3,176.55	$3,442.08	$4,141.70	N/A	N/A
24	$2,983.75	$3,504.90	$3,768.48	$4,560.58	N/A	N/A

THIS VIEW IS FOR AGENT USE ONLY, NOT FOR DISSEMINATION TO CONSUMERS.

The Guaranteed Annualized Premium and Guaranteed Base Policy Death Benefit shown are for the initial level term period only. The Policy is renewable annually until the policy anniversary nearest the insured's 95th birthday. The premiums are guaranteed level for the initial level term period only. The death benefit decreases immediately following the level term period. The post-level term period premiums generally remain the same immediately following the level term period but often become greater in ensuing years. See your policy for details.

Issue Age is Calculated as Age Nearest the Proposed Insured's Birthday.

This Quotation is designed to help you understand the proposed policy. It demonstrates how benefits and premiums are affected by different assumptions. This Quotation does not include riders.

Premiums are shown only for the period for which they are guaranteed to be level. All premiums quoted are guaranteed for the underwriting class shown on the Quotation. The premium rates will ultimately depend on the outcome of the underwriting process and may vary significantly from what is shown on this Quotation.

QoL Flex Term premium rates are current as of May 4th, 2020.

Premiums for other rate classes, ages and payment plans are available. Premium charges will depend on each applicant's evidence of insurability. Premiums increase at the end of the level term period if the policy is renewed. Death benefit remains level and is payable in lump sum, or installments, if so elected. The insurance company may contest the policy for two years from date of policy issue for material misstatements or omissions on the application. Death benefit is payable from any cause, except suicide within first two policy years. In the event of suicide in the first two years, policy is limited to return of premium paid.

Policies Issued by:
American General Life Insurance Company, 2727-A Allen Parkway, Houston, Texas 77019

QoL Flex Term Policy Form Number ICC19-19311 or 19311.

American General Life Insurance Company is the sole issuer of QoL Flex Term Policies.

The underwriting risks, financial and contractual obligations, and support functions associated with the products issued by American General Life Insurance Company (AGL) are its responsibility. Guarantees

Quality of Life...Insurance®
Your Money. Your Insurance. Your Choice.

Life Kit
FLORIDA

Policies issued by American General Life Insurance Company, a member of American International Group, Inc. (AIG)

New Business Transmittal Form

☐ AIG Life Brokerage ☐ AIG Partners Group

Complete this SECTION for Agent's FIRST PIECE OF BUSINESS Only

Agent Name: ______ Date L&C Paperwork submitted to Home Office: ______

Agent Code Number: ______

If Code Number not yet assigned, Agent's SSN or TIN: ______

Policy Number ______ Applicant Name Nelly Calderon Medina DOB 12/27/1957

Agency Number 529901 Agency Name ______

Agent/Service Number 533641 Agent Name Mayte Carratala

☒ New Application
☐ Underwriting Requirements
☐ Delivery Requirements
☐ Reissue (Indicate instructions below)
☐ Other ______

☐ Informal/Trial App (Quote - Authorization required w/personal information)
☐ Previous Informal/Trial/Quick Quote Number ______

CONTACT INFORMATION FOR CASE FOLLOW UP

Name: Melissa Zamora

Phone: 800-325-8907 ext: 3227

Fax: 800-406-1153

E-mail: MZamora@Seeman holtz.com

SPECIAL INSTRUCTIONS

☐ This is a Companion Case ☐ Issue w/Companion Policy # ______

☐ More than one application on same applicant ______

☒ If approved other than applied for, do not issue until we have confirmed applicant's interest in accepting offer

☐ At approval, hold for issue instructions ☐ Draft Initial Premium

ePOLICY DELIVERY INSTRUCTIONS (Availability varies by product and distribution channel)

☐ **ePolicy Delivery (Deliver this policy electronically to the policy owner email address on the application)**
*policy owner email address must be provided on application.

OTHER INFORMATION

APS: ______ ☐ Agent Ordered ☐ Carrier Ordered ☐ Dr. Name: ______

APS: ______ ☐ Agent Ordered ☐ Carrier Ordered ☐ Dr. Name: ______

Inspection Report: ☐ Agent Ordered ☐ Carrier Ordered

OTHER SPECIAL INSTRUCTIONS

Dr. Jorge Camilo Mora ph# 954-442-2828
4/1/19 well visit

Remember: www.aig.com/connext is your source for policy and form information.
By providing complete and accurate information, processing time can be expedited.

AGLC101371 Rev0320

Individual Life Insurance Application
Single or Multiple Insured(s) - Part A
Florida Version

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

1. Primary Proposed Insured

First Name Nelly MI___ Last Name Calderon Medina Gender ☐M ☒F
SSN 770-34-4987 Birthplace* *(US State, or country)* Colombia DOB 12/27/57 Current Age 63
Tobacco Use Has the Primary Proposed Insured ever used any form of tobacco or nicotine products? ☐yes ☒no
Type and *Quantity* Used___ If yes, a current user? ☐yes ☐no If no, date of last use ___
Driver's License ☒yes ☐no License State Florida Number C436-620-57-967-0
If over age of 16 and no license, please explain.___
Address 15646 SW 40th St. City Miramar State FL ZIP 33027
Primary Phone 305-778-3847 Alternate Phone 786-712-1221 Email nellycal27@gmail.com
Employer Self employed Occupation executive assistant Date of Employment (mm/dd/yy) 11/1/2010
Job Duties assits husband with business Average No. of hours worked per week 30
Actively at work? ☒yes ☐no Able to perform all job duties? ☒yes ☐no If either is no, explain ___
Personal Earned Income (Annual): $ 50,000 Household Income (Annual): $ 84,000 Net Worth $ 450,000
Personal Earned Income means monies received for work performed.
If Primary Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force and/or pending on:
Owner $___ Spouse $___ Father $___ Mother $___ Siblings $___ Premium Payor $___
Citizenship U.S. Citizen or Permanent Resident Card holder ☒yes ☐no If no, answer the following:
Country of Citizenship USA Date of Entry___ Visa Type___ (Copy of Visa Required)
Own property or have a mortgage in the U.S.? ☒yes ☐no Plan to remain in the U.S.? ☐yes ☐no

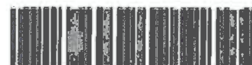
2. Other Proposed Insured

First Name ___ MI___ Last Name ___ Gender ☐M ☐F
SSN ___ Birthplace* *(US State, or country)* ___ DOB___ Current Age___
Relationship to Primary Proposed Insured: ___
Tobacco Use Has the Other Proposed Insured ever used any form of tobacco or nicotine products? ☐yes ☐no
Type and *Quantity* Used___ If yes, a current user? ☐yes ☐no If no, date of last use ___
Driver's License ☐yes ☐no License State ___ Number___
If over age of 16 and no license, please explain.___
Address ___ City ___ State___ ZIP___
Primary Phone ___ Alternate Phone ___ Email ___
Employer ___ Occupation___ Date of Employment (mm/dd/yy) ___
Job Duties ___ Average No. of hours worked per week ___
Actively at work? ☐yes ☐no Able to perform all job duties? ☐yes ☐no If either is no, explain ___
Personal Earned Income (Annual): $___ Household Income (Annual): $ ___ Net Worth $ ___
Personal Earned Income means monies received for work performed.
If Other Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force and/or pending on:
Owner $___ Spouse $___ Father $___ Mother $___ Siblings $___ Premium Payor $___
Citizenship U.S. Citizen or Permanent Resident Card holder ☐yes ☐no If no, answer the following:
Country of Citizenship ___ Date of Entry___ Visa Type___ (Copy of Visa Required)
Own property or have a mortgage in the U.S.? ☐yes ☐no Plan to remain in the U.S.? ☐yes ☐no

3. Owner - Complete if Primary Proposed Insured is not the Owner - *(If Owner is a business, charitable entity or trust, answer question 6 below.)*

First Name ___ MI___ Last Name ___ Gender ☐M ☐F
SSN ___ DOB ___ Relationship to Proposed Insured ___
Driver's License ☐yes ☐no License State ___ Number___

**for identification purposes only*



U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship ______ Date of Entry ______
Visa Type ______ Exp. Date ______
Address ______ City ______ State ______ ZIP ______
Primary Phone ______ Email ______
(If contingent Owner is required, use question 14.)

4. Reason for Insurance - *(If Business, complete Financial Questionnaire.)* protection

5. Beneficiary - *(If Beneficiary is a business, charitable entity or trust, answer question 6 below.)*

No.	Name	DOB mm/dd/yy	SSN	Phone Number	Relationship	Share %	Beneficiary Type
1	Wilder Moreno	11/9/61	769-66-2137	786-712-127	husband	100	☒ Primary ☐ Contingent
	Address: 15646 SW 40th St. Miramar, FL 33027			Email: wilmora2004@gmail.com			
2	Camilo Andres Moreno	8/26/94	770-34-4989	954-696-7523	son	50	☐ Primary ☒ Contingent
	Address: 15646 SW 40st st Miramar, FL 33027			Email: cmcamilomoreno@gmail.com			
3	Lina Marcela Moreno	1/24/99	770-34-4993	954-607-8047	daughter	50	☐ Primary ☒ Contingent
	Address: 15646 SW 40th St. Miramar, FL 33027			Email: LMmorenoc@gmail.com			

6. Entity Information - *Complete if Owner or Beneficiary is a business, charitable entity or trust. If applicable, complete the Certification of Trust.*
(Check the applicable boxes information applies to: ☐ Owner and/or ☐ Beneficiary. **If also the Premium Payor, complete section 11E.)**
Exact Name ______ Tax ID # ______
Address ______ City ______ State ______ ZIP ______
Current Trustee Name ______ Date of Trust ______
Corporate Officer Name ______ Title ______
Email Address of applicable Trustee or Corporate Signer ______
Relationship to Proposed Insured ______ Type of Entity (SCorp, CCorp, DBA, etc.) ______

7. Product - *Signed Illustration/Quotation is required for all UL & VUL products.*
Plan Name (Complete appropriate supplemental application if applicable. For Index UL, complete the Index UL Supplemental Application.)
QOL Flex Term
Term Duration** 10 years Premium Class Quoted Standard
Amount Applied For: Base Coverage $ 250,000 Supplemental Coverage** $ ______
Death Benefit Compliance Test Used**: ☐ Guideline Premium ☐ Cash Value Accumulation **I** Automatic Premium Loan**: ☐ yes ☐ no

8. Death Benefit Options - *(For UL & VUL only)* ☐ Level ☐ Increasing

9. Riders/Benefits - *Refer to Rider Reference Page for riders and benefits available per product.*

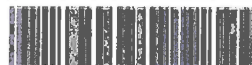
☐ 4 Year Term
☐ 20-Year Benefit Rider
☐ Accidental Death & Dismemberment
☐ Accidental Death Benefit $ ______
☐ Additional Insurance Option $ ______
☐ Additional Insured $ ______
☐ Child Rider[1] $ ______
  ☐ No current children
☐ Chronic Illness Rider (AAS)[2]
☐ Defined Accelerated Benefit
  ☐ Primary Proposed Insured
  ☐ 5% ☐ 10% ☐ Other ______
  ☐ Additional Proposed Insured
  ☐ 5% ☐ 10% ☐ Other ______
☐ Disability Income
  Monthly Benefit $ ______
  Occ Class ______

☐ DI Rider 2 | Monthly Benefit $ ______
☐ DI Rider 5 | Occ Class ______
  Applies to Primary ☐ and/or Spouse ☐
☐ Enhanced Surrender Value
☐ Lapse Protection Benefit Rider
☐ Level Term $ ______
☐ Lifestyle Income[3]
  Withdrawal Benefit Basis % ______
☐ Monthly Guarantee Premium
☐ Select Income
  Monthly Benefit Amount $ ______
  Benefit Duration ______
☐ Single Premium
  Whole Life $ ______
☐ Spouse Level Term $ ______
☐ Spouse/Other Insured $ ______

☐ Surrender Value
  Enhancement Term $ ______
☐ Terminal Illness
☐ Waiver of Monthly Deduction
☐ Waiver of Monthly
  Guarantee Premium
☐ Waiver of Premium
☐ Waiver of Specified
  Premium $ ______
☐ Other
  Amount/Unit(s) ______

1 - Complete Child Rider Supplement
2 - Complete Chronic Illness Supplement
3 - Chronic Illness Rider (AAS) required with Lifestyle Income when AAS is approved. This requirement varies by product. Complete Chronic Illness Supplement, if applicable.

***Complete only if applicable*



10. A. Information for an Additional Policy - *If more than one policy being applied for at this time please complete the section below.*

Individual to be insured is the ☐ Primary Proposed Insured or ☐ Other Proposed Insured listed on this application.

Plan Name ______________________ Term Duration** _____ Premium Class Quoted ______________

Amount Applied For: Base Coverage $ ______________ Supplemental Coverage** $ ______________

Death Benefit Compliance Test Used**: ☐ Guideline Premium ☐ Cash Value Accumulation I Automatic Premium Loan**: ☐ yes ☐ no

Death Benefit Options *(For UL & VUL only)* ☐ Level ☐ Increasing

Riders/Benefits

☐ Accidental Death Benefit $ ________

☐ Child Rider[1] $ ________

☐ No current children

☐ Chronic Illness Rider (AAS)[2]

☐ Lifestyle Income[3]

Withdrawal Benefit Basis % ______

☐ Terminal Illness

☐ Waiver of Monthly Deduction

☐ Waiver of Monthly Guarantee Premium

☐ Waiver of Premium

☐ Other Rider/Benefit #1 $ ________

Amount/Units ________

☐ Other Rider/Benefit #2 $ ________

Amount/Units ________

1 - Complete Child Rider Supplement
2 - Complete Chronic Illness Supplement
3 - Chronic Illness Rider (AAS) required with Lifestyle Income when AAS is approved. This requirement varies by product. Complete Chronic Illness Supplement, if applicable.

If beneficiary is to be other than as listed in question 5, please complete the following:

No.	Name	DOB mm/dd/yy	SSN	Phone Number	Relationship	Share %	Beneficiary Type
1							☐ Primary ☐ Contingent
	Address:			Email:			
2							☐ Primary ☐ Contingent
	Address:			Email:			
3							☐ Primary ☐ Contingent
	Address:			Email:			

10. B. Information for an Additional Policy - *If more than one policy being applied for at this time please complete the section below.*

Individual to be insured is the ☐ Primary Proposed Insured or ☐ Other Proposed Insured listed on this application.

Plan Name ______________________ Term Duration** _____ Premium Class Quoted ______________

Amount Applied For: Base Coverage $ ______________ Supplemental Coverage** $ ______________

Death Benefit Compliance Test Used**: ☐ Guideline Premium ☐ Cash Value Accumulation I Automatic Premium Loan**: ☐ yes ☐ no

Death Benefit Options *(For UL & VUL only)* ☐ Level ☐ Increasing

Riders/Benefits

☐ Accidental Death Benefit $ ________

☐ Child Rider[1] $ ________

☐ No current children

☐ Chronic Illness Rider (AAS)[2]

☐ Lifestyle Income[3]

Withdrawal Benefit Basis % ______

☐ Terminal Illness

☐ Waiver of Monthly Deduction

☐ Waiver of Monthly Guarantee Premium

☐ Waiver of Premium

☐ Other Rider/Benefit #1 $ ________

Amount/Units ________

☐ Other Rider/Benefit #2 $ ________

Amount/Units ________

1 - Complete Child Rider Supplement
2 - Complete Chronic Illness Supplement
3 - Chronic Illness Rider (AAS) required with Lifestyle Income when AAS is approved. This requirement varies by product. Complete Chronic Illness Supplement, if applicable.

If beneficiary is to be other than as listed in question 5, please complete the following:

No.	Name	DOB mm/dd/yy	SSN	Phone Number	Relationship	Share %	Beneficiary Type
1							☐ Primary ☐ Contingent
	Address:		Email:				
2							☐ Primary ☐ Contingent
	Address:		Email:				
3							☐ Primary ☐ Contingent
	Address:		Email:				

11. Premium Payment ☒ Modal $ ____________ ☐ Single $____________ ☐ Additional/Lump Sum $ ____________

A. Frequency of modal premium: ☐ Annual ☐ Semi-annual ☐ Quarterly ☒ Monthly *(Bank Draft only)*

B. Method: ☐ Direct Billing ☒ Bank Draft (*Complete Bank Draft Authorization)* ☐ List Bill: Number____________
☐ Credit Card - Initial Premium Only *(Complete Credit Card Authorization)* ☐ Other *(Please explain)* ____________

C. Amount submitted with application $ Ø

D. Special Dating *(not applicable for VUL products)*: Save Age.................... ☐ yes ☒ no

E. Premium Payor *(Complete if Payor is other than Owner or if Owner is Trustee.)*

First Name ____________ MI ___ Last Name ____________ Gender ☐ M ☐ F

SSN or Tax ID # ____________ Relationship to Primary Proposed Insured ____________

Driver's License ☐ yes ☐ no License State ________ Number ____________ DOB ________

U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship ______ Date of Entry ______ Visa Type ______ Exp. Date ______

Address ____________ City ____________ State______ ZIP ______

If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form.

12. Existing Coverage and Replacements

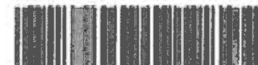
"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

A. Do any of the Proposed Insureds have any existing annuity, life insurance, or disability insurance or have any application pending for such coverage with this Company or any other company?.................... ☐ **yes** ☒ **no**

B. If question 12A is answered "yes", please provide the following information:

No.	Policy Number	Year of Issue	Coverage (see below)	Benefit Period (if DI)	Type (see below)	Coverage Being Replaced?	1035 Exchange?
1						☐Y ☐N	☐Y ☐N
	Company Name: ____________			Amount of Coverage $ ________			
	Proposed Insured Name: ____________						
2						☐Y ☐N	☐Y ☐N
	Company Name: ____________			Amount of Coverage $ ________			
	Proposed Insured Name: ____________						
3						☐Y ☐N	☐Y ☐N
	Company Name: ____________			Amount of Coverage $ ________			
	Proposed Insured Name: ____________						
4						☐Y ☐N	☐Y ☐N
	Company Name: ____________			Amount of Coverage $ ________			
	Proposed Insured Name: ____________						

Coverage: LI=Life, H=Health, A=Annuity, LT=LTC, DI= Disability Income **Type:** i=individual, b=business, g=group, p=pending



13. Background Information - *Provide details specified for all "Yes" answers or complete applicable questionnaires.*

	Primary Proposed Insured	Other Proposed Insured
A. In the past five years, have any of the Proposed Insureds flown as a pilot, student pilot or crew member of any aircraft, or have any intention to do so in the next two years? *(If yes, complete the Aviation Questionnaire)*	☐ yes ☒ no	☐ yes ☐ no
B. In the past five years, have any of the Proposed Insureds engaged in motor sports events or racing (auto, truck, motorcycle, boat, aircraft, or other motorized vehicles); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning,) or have any intention to do so in the next two years? *(If yes, complete the Avocation Questionnaire)*	☐ yes ☒ no	☐ yes ☐ no
C. Have any of the Proposed Insureds ever had an application for insurance modified, rated, declined, postponed or withdrawn? *(If yes, list type of coverage, date and reason)* Proposed Insured Name: ____ Details: ____	☐ yes ☒ no	☐ yes ☐ no
D. Have any of the Proposed Insureds ever filed for bankruptcy, or have the intention to seek bankruptcy protection within the next 12 months? *(If filed, list chapter filed, date, reason, and discharge date)* Proposed Insured Name: ____ Details: ____	☐ yes ☒ no	☐ yes ☐ no
E. In the past five years, have any of the Proposed Insureds been convicted of any driving violations to include driving under the influence of alcohol or drugs? *(If yes, list date, state, license #, and specific violation)* Proposed Insured Name: ____ Details: ____	☐ yes ☒ no	☐ yes ☐ no
F. Have any of the Proposed Insureds ever been convicted of a felony or misdemeanor, or currently incarcerated or on parole or probation? (If yes, list date, county, state, charge, and current status) Proposed Insured Name: ____ Details: ____	☐ yes ☒ no	☐ yes ☐ no
G. Are any of the Proposed Insureds an active duty service member of the U.S. Armed Forces? *(If yes, provide Pay Grade, Rank and any known foreign assignments, and complete any required Military Sales Disclosure)* Proposed Insured Name: ____ Details: ____	☐ yes ☒ no	☐ yes ☐ no
H. Within the next 2 years is there any intention that any party, other than the listed Owner or Beneficiary, will obtain any right, title, or interest in any policy issued on the life of any of the Proposed Insureds as a result of this application?	☐ yes ☒ no	☐ yes ☐ no
I. Within the next 2 years does the Owner or any of the Proposed Insureds intend to finance any of the premium required to pay for this policy through a financing or loan agreement?	☐ yes ☒ no	☐ yes ☐ no
J. Is the Owner, any of the Proposed Insureds, or any person or entity, being paid (cash, services, etc.) as an incentive to enter into this transaction? *(If yes, describe the incentive)* Proposed Insured Name: ____ Details: ____	☐ yes ☒ no	☐ yes ☐ no

14. The space below may also be used to elaborate on answers to any questions on this application.

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured (and any Owner or Other Proposed Insured signing below) acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement ("LTLIA"), I understand and agree that, even if I paid a premium, no insurance will be in effect under this application or under any new policy or any rider(s) that may be issued by the Company unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of any Proposed Insured(s) that would change the answer to any question in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that, if all three conditions above are not met: (1) no insurance will be in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy (and the Other Proposed Insured under a joint and survivorship life policy, if applicable) and only if the conditions set forth in the LTLIA are met. I understand and agree that such temporary insurance is not available as to any riders or any accident and/or health insurance.

I understand and agree that no agent is authorized to accept risks or pass upon insurability, make or modify contracts, or waive any of the Company's rights or requirements.

I have received a copy of or have been read the Notices to the Proposed Insured(s).

I authorize any medical professional; any hospital, clinic or other health care facility; any pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; the Medical Information Bureau (MIB); or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability, or that of any minor child for whom application for insurance is being made, to disclose and give to the Company, its legal representatives, its affiliated service companies, and its affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information concerning me, or any minor child for whom application for insurance is being made. Other information may include, but is not limited to, items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records, etc.

I understand that the information obtained will be used by the Company to determine: (1) eligibility for insurance; (2) eligibility for benefits under an existing policy; and (3) verification of answers and statements on this application. I further authorize the Company to conduct a media or electronic search on me. Any information gathered during the evaluation of my application may be disclosed to: other insurers to whom I may apply for coverage; reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931. This consent will be valid for 24 months from the date of this application or for such other period permitted by applicable state law where the policy is issued. I agree that a copy of this consent will be as valid as the original. I authorize the Company, its affiliated insurers, and its affiliated service companies to obtain an investigative consumer report on me. I understand that I may: (1) request to be interviewed for the report; and (2) upon written request, receive a copy of such report.

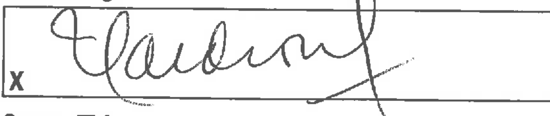
☐ Check if you wish to be interviewed.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IRS Certification: Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding (enter exempt payee code*, if applicable: ______), OR (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person*, and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (enter exemption from FATCA reporting code, if applicable: ______).
**Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For contributions to an individual retirement arrangement (IRA) and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. *See General Instructions provided on the IRS Form W-9 available from IRS.gov. ** If you can complete a Form W-9 and you are a U.S. citizen or U.S. resident alien, FATCA reporting may not apply to you. Please consult your own tax advisors.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Owner Signature



X

Owner Title ______________________
(If Corporate Officer or Trustee)

Owner signed at (city, state) Miramar, FL

Owner signed on (date) 9/15/20

Primary Proposed Insured Signature (if other than Owner)

X

(If under age 16, signature of parent or guardian)

Agent(s) Signature(s)

I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* Mayte Carratala

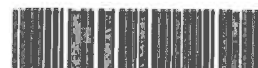
State License # W473391

Writing Agent Signature X Mayte

Other Proposed Insured Signature

X

(If under age 16 and coverage exceeds $150,000, signature of both parents required)



Agent's Report

Policy # (if known): ______________

☒ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

Nelly		Calderon Medina	12/27/57	770-34-4987
First Name	MI	Last Name	Date of Birth	Social Security #

1. Is more than one application being submitted at this time or pending for the Proposed Insured(s), family members, or business associates? *(If Yes, provide details in the Remarks section below.)* ☐ yes ☒ no
2. Does any Proposed Insured(s) have any existing or pending annuities or life insurance policies? *(If yes, certain states require completion of replacement-related forms even when other life insurance or annuities are not being replaced by the policy being applied for - please attach such forms.)* ☐ yes ☒ no
3. If yes to question 2, do you have any information the Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity in connection with the policy being applied for? *(If yes, please provide details in the Remarks section below and attach replacement-related forms.)* ☐ yes ☒ no
4. Are you aware of any other information that would adversely affect the eligibility, acceptability, or insurability of any Proposed Insured(s)? ☐ yes ☒ no

5a. Will a medical exam be conducted? ☒ yes ☐ no
5b. If no, did you personally see all Proposed Insured(s) when the application was written? *(If no, provide explanation in the Remarks section below.)* ☐ yes ☐ no

6. If accidental death is applied for, what is the total amount of accident coverage inforce and applied for? ______________
7. Is applicant applying for an applicable QoL Advantage option available on select QoL Products? *(If yes, complete QoL Advantage Form)* ☐ yes ☒ no
8. Did you provide the Owner with a Limited Temporary Life Insurance Agreement? ☐ yes ☒ no
9. **Remarks, Details, and Explanations** *(Please include information on any policy collateral assignments, etc.)*

AGLC108107-2015 Rev0516

9. Remarks, Details, and Explanations *(continued)*

10. Agent/Agency Information *(Please list servicing agent first)*

Note: The commission designation cannot be 100% for an agent other than the writing agent. Total allocations must equal 100%. Use whole percentages only; 0% is not a valid entry.

	Agent(s) Splitting Application	Agency Number	Local Office Code	Agent Number	Percentage of Split
Servicing Agent:					%
	Mayte Carratala	52999	Q388	533641	100 %
					%
					%
					%

11. Agent Agreement and Signature

I certify that the above information is true and complete to the best of my knowledge and belief. If I become aware of information contrary to any of the answers contained in the life insurance application to which this Agent's Report relates or contained in any supplemental applications, questionnaires, or other forms, I will notify the company of such information.

Writing Agent Name *(Please print)* Mayte Carratala Date 9/15/20

Writing Agent Signature X [signature]

State License # W473391 Phone # 800-325-8907

Email mzamora@seemanholtz.com Fax # ______

Summary and Disclosure Notice for Critical Illness Accelerated Death Benefit Rider, Chronic Illness Accelerated Death Benefit Rider, and Terminal Illness Accelerated Death Benefit Rider

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
A member of American International Group, Inc. (AIG)

Receipt of a benefit under an accelerated death benefit rider will reduce any death benefit that may become payable under the policy to which the rider is attached.

PURPOSE OF THIS SUMMARY AND DISCLOSURE

This Summary provides a brief description of the basic features of the accelerated death benefit riders described below. This is not an insurance contract, but only a summary of the coverage provided by each rider. If a policy is issued, it is important to check the policy for details on any accelerated death benefit rider that is included in the policy. It is also important to carefully read any accelerated death benefit rider included in the policy.

TAX CONSEQUENCES

Benefits paid under the Critical Illness Accelerated Death Benefit Rider may cause the Owner to incur a tax obligation. Benefits paid under the Chronic Illness Accelerated Death Benefit Rider or the Terminal Illness Accelerated Death Benefit Rider are intended to qualify for favorable tax treatment but MAY BE TAXABLE IN SOME CIRCUMSTANCES. Neither the Company nor its agents are authorized to offer you tax advice. You should consult your accountant, attorney or other qualified tax professional to assess the impact of a benefit. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated death benefit rider.

ACCELERATED DEATH BENEFIT RIDER DESCRIPTIONS

Critical Illness Accelerated Death Benefit Rider

The Critical Illness Accelerated Death Benefit Rider provides that the Owner may elect an accelerated death benefit if the Insured Person is diagnosed as having a Qualifying Critical Illness, subject to the provisions of the rider. Qualifying Critical Illness means the occurrence of any of the following illnesses or conditions as to an Insured Person – Major Heart Attack, Stroke, Coronary Artery Bypass, Invasive Cancer, End Stage Renal Failure. Major Organ Transplant, Paralysis, Coma and Severe Burn:

1. Which a physician has diagnosed within 365 days of the date of our receipt of certification at our claim office pursuant to a claim under the rider; and
2. Which a physician has diagnosed after such Insured Person's coverage under the rider has been in force for 30 consecutive days, or 90 consecutive days for Invasive Cancer; and
3. Which is not an occurrence of the same illness or condition for which an accelerated benefit was previously paid under the rider as to the Insured Person.

Chronic Illness Accelerated Death Benefit Rider

The Chronic Illness Accelerated Death Benefit Rider provides that the Owner may elect an accelerated death benefit if the Insured Person is certified as having a Qualifying Chronic Illness, subject to the provisions of the rider. Qualifying Chronic Illness means an illness or condition that:

(1) A licensed health care practitioner has certified within the past 12 months as affecting the Insured Person so that he or she:

  (a) Is unable to perform, without substantial assistance from another person, at least two Activities of Daily Living for a period of at least 90 consecutive days due to a loss of functional capacity; or

  (b) Requires substantial supervision to protect such Insured Person from threats to health and safety due to Severe Cognitive Impairment; and

(2) A licensed health care practitioner has certified within the past 12 months as affecting the Insured Person so that he or she is under a plan of care prescribed by a licensed health care practitioner for necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services and for maintenance or personal care services required by a person with such illness or condition; and

(3) A licensed health care practitioner has certified after such Insured Person's coverage under the rider has been in force for 30 consecutive days.

No Chronic Illness Accelerated Death Benefit will be payable for an illness or condition caused by alcoholism, drug addiction, or a mental or nervous disorder (except for disorders comparable to Alzheimer's disease and similar forms of irreversible dementia).

The term "Elimination Period" means a period of 90 consecutive days beginning at any time after the Insured Person's coverage under the rider has been in force for 30 consecutive days, during which Elimination Period the Insured Person must continuously have a Qualifying Chronic Illness prior to eligibility for benefits under this rider. No Accelerated Benefit is payable during the Elimination Period.

The Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting and Transferring.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:

(1) Short-term or long-term memory; and

(2) Orientation as to people, places or time; and

(3) Deductive or abstract reasoning.

Terminal Illness Accelerated Death Benefit Rider

The Terminal Illness Accelerated Death Benefit Rider provides that the Owner may elect an accelerated death benefit if the Insured Person is certified as having a Qualifying Terminal Illness, subject to the provisions of the rider. Qualifying Terminal Illness means an illness or condition which a physician has diagnosed and reasonably expects to result in the Insured Person's death within 12 months or less from the date of diagnosis.

Accelerated Benefit

The term "Accelerated Benefit" means each Critical Illness, Chronic Illness, or Terminal Illness Accelerated Death Benefit Amount paid to the Owner during the Insured Person's lifetime.

Critical, Chronic, and Terminal Illness Accelerated Death Benefit Amounts

The terms "Critical Illness Accelerated Death Benefit Amount," "Chronic Illness Accelerated Death Benefit Amount," and "Terminal Illness Accelerated Death Benefit Amount" mean:

(1) The maximum dollar amount that We determine can be payable with respect to a claim under the rider to the Owner upon satisfaction of all applicable provisions and requirements under the applicable rider and the Policy; or

(2) Any lesser amount elected by the Owner to be received under the rider.

The Critical, Chronic, or Terminal Illness Accelerated Death Benefit Amount for a Qualifying Critical Illness, Chronic Illness, or Terminal Illness, as applicable, will never be less than the applicable Minimum Accelerated Benefit Amount for such Qualifying Critical, Chronic, or Terminal Illness.

The Critical, Chronic, or Terminal Illness Accelerated Death Benefit Amount will be equal to the death benefit you elect to accelerate, less the following deductions:

(1) The actuarial discount determined by us; and

(2) An administrative fee, not to exceed the maximum administrative fee shown in the rider; and

(3) Payment of any unpaid but due policy premiums; and

(4) If applicable, payment of a pro rata amount of any policy loans.

If we determine that the conditions for payment of an accelerated benefit have been met, we will notify you of the Critical, Chronic, or Terminal Illness Accelerated Death Benefit Amount that you may elect, if any, for a Qualifying Critical, Chronic, or Terminal Illness, and we will send you an election form. You must complete the election form and return it to us within the Election Period shown in the rider. The failure to provide the required election form within the election period may preclude payment of a benefit.

You may choose either to elect or not to elect a Critical, Chronic, or Terminal Illness Accelerated Death Benefit Amount that will be paid as an Accelerated Benefit for such Qualifying Critical, Chronic, or Terminal Illness, as applicable.

If, as to the occurrence of a Qualifying Critical Illness, you decide not to elect a Critical Illness Accelerated Death Benefit Amount or if you decide to elect to receive less than the maximum Accelerated Benefit for such Qualifying Critical Illness, you cannot thereafter elect a Critical Illness Accelerated Death Benefit Amount for the same occurrence of such Qualifying Critical Illness.

Any Accelerated Benefit with respect to a Critical Illness Accelerated Death Benefit Amount or a Terminal Illness Accelerated Death Benefit Amount will be paid in one lump sum. Any Accelerated Benefit with respect to a Chronic Illness Accelerated Death Benefit Amount may be paid in one lump sum or in periodic payments.

MEDICAID/GOVERNMENT BENEFITS

Receipt of accelerated death benefits from a life insurance policy MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI"), OR OTHER GOVERNMENT PROGRAMS. In addition, exercising the option to accelerate the death benefit and receiving that benefit before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

IMPORTANT NOTICES

There is no premium or charge to include a Critical Illness Accelerated Death Benefit Rider, Chronic Illness Accelerated Death Benefit Rider, or Terminal Illness Accelerated Death Benefit Rider on a policy. Accelerated benefits do not and are not intended to qualify as long-term care insurance.

Important Consumer Disclosures Applicable to Critical Illness Accelerated Death Benefit Rider, Chronic Illness Accelerated Death Benefit Rider, and Terminal Illness Accelerated Death Benefit Rider

(1) When filing a claim for Qualifying Critical Illness under a Critical Illness Accelerated Death Benefit Rider, for Qualifying Chronic Illness under a Chronic Illness Accelerated Death Benefit Rider or for Qualifying Terminal Illness under a Terminal Illness Accelerated Death Benefit Rider, the claimant must provide to the Company a completed claim form and then-current Certification which must be received at its Administrative Center.

(2) If a benefit under the Critical Illness Accelerated Death Benefit Rider is payable, the Company will provide the Owner with one (1) opportunity to elect a Critical Illness Accelerated Death Benefit Amount as to the occurrence of the Qualifying Critical Illness in question. To make such an election, the Owner must complete an election form and return it to AGL within the Election Period set forth in the rider (i.e., within 60 days of the owner's receipt of the election form). **The Company will not provide a later opportunity to elect a Critical Illness Accelerated Death Benefit Amount under a Policy as to the same occurrence of a Qualifying Critical Illness.**

(3) If a benefit under the Chronic Illness Accelerated Death Benefit Rider or under the Terminal Illness Accelerated Death Benefit Rider is payable, the Company will provide the Owner with an opportunity to elect a Chronic Illness Accelerated Death Benefit Amount as to the Qualifying Chronic Illness in question or to elect a Terminal Illness Accelerated Death Benefit Amount as to the Qualifying Terminal Illness in question, as applicable. To make an election, the Owner must complete an election form and return it to AGL within 60 days of the Owner's receipt of the election form.

(4) Under certain circumstances where an insured's mortality (i.e., our expectation of the insured's life expectancy) is not significantly changed by a Qualifying Critical Illness or a Qualifying Chronic Illness and, notwithstanding the Minimum Accelerated Benefit Amount provision, the accelerated benefit may be zero.

(5) The failure to provide a required election form (with the requested attachments) within the Election Period provided by the applicable rider (i.e., within 60 days of the owner's receipt of the election form) may preclude payment of a benefit.

(6) Benefits payable under an accelerated death benefit rider may be taxable. Neither American General Life Insurance Company nor any agent representing it is authorized to give legal or tax advice. Please consult a qualified legal or tax advisor regarding questions concerning the information and concepts contained in this material.

(7) Generally, we will send you an IRS Form 1099-LTC if you receive an accelerated death benefit on account of a Qualifying Chronic Illness or a Qualifying Terminal Illness. We will send you an IRS Form 1099-R if you receive an accelerated death benefit on account of a Qualifying Critical Illness.

The sum that will be included in Box 2 (Accelerated death benefits paid) of IRS Form 1099-LTC or in Box 1 (Gross distribution) of IRS Form 1099-R will be the actual sum you received by check or otherwise minus any refund of premium and/or loan interest included with our benefit payment plus any unpaid but due policy premium, if applicable, and/or pro rata amount of any loan balance.

(8) The maximum amount of life insurance death benefits that may be accelerated as to an Insured Person under all accelerated benefit riders is the lesser of the existing amount of such death benefits or a lifetime maximum of $2,000,000.

(9) See your policy for details.

Notice Regarding Substitution of one Policy with Accelerated Death Benefit Riders (ABRs) for a previously-issued Policy with different ABRs

If I am applying to substitute a policy with ABRs for a previously-issued policy with different ABRs, I acknowledge that I have carefully compared (or have had the opportunity to carefully compare) the benefits of the replaced policy with the benefits of the new policy for which I am applying. I further acknowledge:

(1) That some or all of the benefits under the ABRs on the existing policy differ from those in the new ABRs;

(2) That some or all of the benefits under the existing ABRs on the existing policy noted may be more advantageous to me than those under the applied-for ABRs;

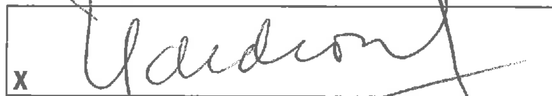
(3) That some of benefits under the new ABRs may be more advantageous to me than those under the existing ABRs; and

(4) That the applied-for ABRs may exclude coverage for claims arising from conditions for which the existing ABRs on the policy noted above may provide coverage.

ACKNOWLEDGMENT

I acknowledge that I have reviewed this Summary and Disclosure Notice and have received a copy of it, if required, and will be provided a copy with my policy.

Owner's Signature



X

Owner signed on (date) 9/15/20

Owner Title ______________________

(If Corporate Officer or Trustee)

The applicant was shown a copy of this Summary and Disclosure Notice prior to executing an application.

Agent's Signature

X

Agent signed on (date) 9/15/20

SUMMARY AND DISCLOSURE NOTICE FOR CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

American General Life Insurance Company
A member of American International Group, Inc. (AIG)

Receipt of a benefit under an accelerated death benefit rider will reduce any death benefit that may become payable under the policy to which the rider is attached.

PURPOSE OF THIS SUMMARY AND DISCLOSURE

This Summary provides a brief description of the basic features of the accelerated death benefit rider described below. This is not an insurance contract, but only a summary of the coverage provided by the rider.

If a policy is issued, it is important to check the policy for details on any accelerated death benefit rider that is included in the policy. It is also important to carefully read any accelerated death benefit rider included in the policy.

TAX CONSEQUENCES

Benefits under the accelerated death benefit rider are intended to qualify for favorable tax treatment. However, accelerated death benefits payable under an accelerated death benefit rider MAY BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated death benefit rider.

BENEFIT DESCRIPTION

Accelerated benefit means the payment, during the Insured's lifetime, of a portion of the death benefit under the policy as described in an accelerated death benefit rider.

The Chronic Illness Accelerated Death Benefit Rider provides that the Owner may elect an accelerated death benefit if the Insured is Chronically Ill, subject to the provisions of the rider.

Chronically Ill means that the Insured has been certified or re-certified by a licensed health care practitioner within the preceding 12-month period as:

1. Being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period of at least 90 consecutive days due to a loss of functional capacity; or
2. Requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

The Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting and Transferring.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:

1. Short-term or long-term memory; and
2. Orientation as to people, places or time; and
3. Deductive or abstract reasoning.

BENEFIT PAYMENTS

The Accelerated Benefit may be paid in Monthly Benefits or in a lump sum.

The Monthly Benefit is the amount paid each month beginning on the first monthly deduction day following the date that the Insured becomes eligible for Monthly Benefits. For each 12-month benefit period, you may select the Monthly Benefit amount. Such amount must not be less than the minimum monthly benefit, shown in the rider, or more than the maximum monthly benefit.

You select the method of calculation of the maximum monthly benefit. It can be based on the monthly equivalent of the per diem limitations declared by the Internal Revenue Service or be based on a percentage of the lifetime maximum benefit payable under the rider.

For any benefit period, you may request the lump sum option instead of any other benefit.

EFFECT OF BENEFIT PAYMENT ON POLICY
Each Monthly Benefit payment will reduce certain policy components by a proportional amount. This proportion will equal the Monthly Benefit payment, before reduction for repayment of policy loans, divided by the Death Benefit immediately before the payment. The components that will be reduced by this provision are:

1. Accumulation Value; and
2. Specified Amount; and
3. Surrender Charges, if any; and
4. Continuation guarantee account value, if any; and
5. Monthly Guarantee Premium, if any; and
6. Policy loan amount, if any.

An amount equal to the reduction in policy loan value will be applied as a loan repayment, and thus will reduce the Accelerated Benefit payments.

LIMITATIONS
The Accelerated Benefit will be subject to the following limitations:

1. This benefit is not intended to allow third parties to cause you to involuntarily access the Policy proceeds payable to the named Beneficiary. Therefore, the Accelerated Benefit will not be available if you are required to request it for any third party, including any creditor, government agency, trustee in bankruptcy or any other person or as the result of a court order.
2. If the Insured dies after a request for any Accelerated Benefit has been submitted and before You receive an Accelerated Benefit payment, such request will be voided and the Policy's Death Benefit will be payable.
3. If the Insured dies before all Accelerated Benefit payments have been received, all remaining payments will be voided and the Policy's Death Benefit will be payable, subject to all other Policy provisions.

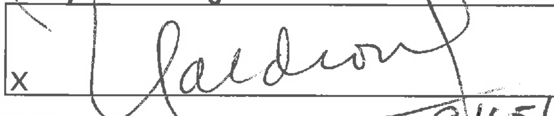
MEDICAID/GOVERNMENT BENEFITS
Receipt of accelerated death benefits from a life insurance policy MAY ADVERSELY AFFECT YOUR ELIGIBILITY FOR MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI"), OR OTHER GOVERNMENT PROGRAMS. In addition, exercising the option to accelerate the death benefit and receiving that benefit before you apply for these programs, or while you are receiving government benefits, may adversely affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

IMPORTANT NOTICES
There is a charge to include a Chronic Illness Accelerated Death Benefit Rider on a policy. The monthly cost of insurance for the rider will be added to the monthly deduction for the policy. The maximum rider cost of insurance rates per unit of coverage are shown in the rider.

Accelerated benefits do not and are not intended to qualify as long-term care insurance.

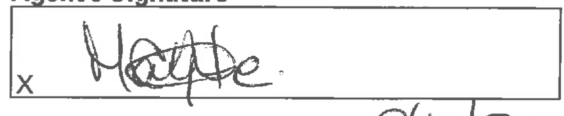
ACKNOWLEDGMENT
I acknowledge that I have reviewed this Summary and Disclosure and have received a copy of it or will be provided a copy with my policy.

Policyowner's Signature



Policyowner signed on (date) 9/15/20
Policyowner's name (printed) Nelly Calderon Medina

Agent's Signature



Agent signed on (date) 9/15/20

The applicant was shown a copy of this Summary and Disclosure prior to executing an application.

HIV Testing and Consent
Florida Version

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

Notice and Consent for Bodily Fluids Testing Which May Include AIDS Virus (Antibody) Testing

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your bodily fluids (blood, urine, and/or oral fluid) for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related bodily fluids test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Results

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Results

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health and Rehabilitation. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: Dr. Jorge Camilo Mora
Address: 501 NW 179th Ave Pembroke Pines, FL 33029

Consent

I have read and I understand this Notice and Consent for AIDS-Related Bodily Fluid Testing. I voluntarily consent to the withdrawal of blood from me and/or collection of other bodily fluids, the testing of bodily fluids, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

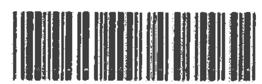
Signature of Proposed Insured or Parent/Guardian

X [signature]

Date signed 9/15/20
Name of Proposed Insured (printed) Nelly Calderon Medina

Address of Proposed Insured 15646 SW 40th St.
Miramar, FL 33027

Submit this form with the application



AGLC0335-10 Rev0516

Secondary Addressee Designation
Florida Version

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

You have the right to designate one person, in addition to the applicant or policyowner, to receive notice of lapse or cancellation of a policy for nonpayment of premium. What does this mean? It means that a copy of the notice of lapse or cancellation that is sent to the policyowner will also automatically be sent to a second person, selected by you, who can assist you in making timely payments in order to prevent a lapse in coverage.

You are under no obligation to designate a secondary addressee, however if you would like to do so, please complete the information below and submit it with your application for life insurance or at such time as you may choose to designate a secondary addressee. **Customer Instruction:** If this designation form is for an existing policy that you own, please send the form to the following address: PO Box 305355 • Nashville, TN 37230-5355.

The policyowner may change the designation at any time the policy is in force by submitting a written notice to the Company containing the name and address of the secondary addressee.

Note: Your designation on this form will replace and revoke any prior designations of secondary addressees previously made by you.

Secondary Addressee:

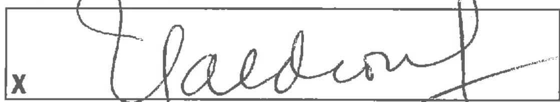
Name: Wilder Moreno

Address: 15646 SW 40th St.

City: Miramar State: Florida ZIP: 33027

Home Phone: 786-712-1221

Applicant/Policyowner's Signature



Applicant/Policyowner signed on (date) 9/15/20

Applicant/Policyowner's name (printed) Nelly Calderon Medina

Policy Number(s), if known:

AGLC108036-FL Rev0516

HIPAA Authorization

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

Nelly Calderon Medina 12/27/57
Name of Insured/Proposed Insured (Please Print) **Date of Birth**

I, the Insured/Proposed Insured above or the Insured/Proposed Insured's Personal Representative acting on behalf of the Insured/Proposed Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated company, (AGL, US Life and affiliated companies collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth

I hereby authorize each of the following entities ("Providers") to provide the information outlined above:

- any physician, nurse or medical practitioner or practitioner group;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any of the Companies (as defined above) which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Companies are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I understand that the Recipients requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in an efficient manner, including electronic interchange through a Health Information Exchange or directly through my Providers' electronic health record system.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P.O. Box 9000, Amarillo, TX 79105-9000. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Insured/Proposed Insured or Insured/Proposed Insured's Personal Representative

X [signature]

Signed on (date) 9/15/20

Signor name (printed) Nelly Calderon Medina

Relationship ____________

Description of Authority of Personal Representative (if applicable) ____________

Control Number/Policy Number ____________

AGLC100633 Rev0716

Notice to Applicant Regarding Replacement of Life Insurance
Florida Version

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer by placing **your initials in the appropriate box below**.

[ ] Yes   [NCM] No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

Applicant's Signature
X [signature]

Applicant signed on (date) 9/15/20

Applicant's name (printed) Nelly Calderon Medina

Agent's Signature
X [signature]

Agent signed on (date) 9/15/20

Agent's name (printed or typed) Maite Carratala

Agent's company (printed or typed) Seeman Holtz

Agent's address (printed or typed) 301 Yamato Rd. St. 2222 Boca Raton, FL 33431

Information on policies which may be replaced:

Company Name	Policy Number	Name of Insured

Florida Policy Disclosure Form

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

PLEASE READ CAREFULLY. This information has been prepared for you so that you may make an informed decision on the use of your policy values to fund the purchase of a new policy. Please see the reverse side of this form for explanatory notes and instructions as to how this form is completed.

PART A - CURRENT POLICY INFORMATION ☐ **LIFE** ☐ **ANNUITY**

Policyowner Name: ____________ Policy Number: ____________

Current Death Benefit: $ ________ Current Premium Amount: $ ________ Mode of Payment: ________

Cash Surrender Value $ ________ Paid-Up Addition Value: $ ________ Dividend Value: $ ________

NOTE: The BENEFIT and VALUES stated above will be reduced as funds are used to purchase the policy proposed in Part B, below.

PART B - PROPOSED POLICY INFORMATION ☒ **LIFE** ☐ **ANNUITY**

Initial Death Benefit: $ 250,000 Proposed Premium Amount: $ 100.32 Mode of Payment: Monthly

Proposed Effective Date: ________ Premiums Payable to Age 74 or for 10 years.

NOTE: If you are replacing your current policy, or using 25% or more of your policy value, you may request a WRITTEN comparison between your current policy and the proposed policy. The comparison is to illustrate the policy values for both policies.

PART C - SOURCE OF FUNDING FOR THE PROPOSED POLICY

A loan in the amount of $ ________ will be taken from the value of your CURRENT POLICY each ________ (mode) bearing a current loan interest rate of ________ %.

A partial surrender in the amount of $ ________ will be taken from the value of your CURRENT POLICY each ________ (mode).

A dividend withdrawal in the amount of $ ________ will be taken from the value of your CURRENT POLICY each ________ (mode).

PART D - YOUR CURRENT POLICY COULD TERMINATE

If the policy values of your CURRENT POLICY are used as a source of funding for the purchase of an additional policy, it is estimated that your CURRENT POLICY will terminate on ____________ (date).

It is estimated that you will begin making premium payments for the PROPOSED POLICY from your own funds on

________ (date) in the amount of $ ________ to be paid each ________ (mode).

NOTE: Since the values and premiums stated on this form may change over time, the estimated date upon which you will need to begin making premium payments from your own funds for the PROPOSED POLICY may also change. Estimates as to dates when policies will terminate or payments must begin assume the continuation of current (or guaranteed) factors, and such calculations are based upon the assumption that any premiums or interest due on loans are paid when due.

Policyowner's Signature

X [signature]

Policyowner signed on (date) 9/15/20

Agent or Company Officer's Signature

X [signature]

Signature signed on (date) 9/15/20

Florida License ID W473391

Corporate Title Agent.

(See reverse side for instructions)

POLICY DISCLOSURE FORM

COMPLETE ONE FORM FOR EACH PREVIOUSLY ISSUED POLICY
ANY REQUIRED REPLACEMENT AND SALES FORMS MUST ALSO BE COMPLETED
ONE COPY IS DELIVERED TO THE POLICYOWNER AND ONE COPY MAINTAINED BY THE INSURER.

Any and all information applicable to the transaction shall be fully and completely disclosed on Form OIR-D0-1180 (AGLC120Z8C). If the information requested does not apply to the transaction, the words "not applicable" or "N/A" shall be entered.

PART A

The information to be disclosed in Part A of Form OIR-D0-1180 (AGLC120Z8C) shall apply to the current, in-force policy for which policy values are being utilized as a source of funding for the purchase of additional insurance contract(s). For purposes of this form, "current death benefit" is defined as the sum of the death benefit payable under the base policy, all life insurance riders covering the principal insured (other than special contingency death riders), paid-up additional insurance and dividends, minus any outstanding indebtedness. The term "cash surrender value" is defined as the cash value of the policy or contract net of any outstanding indebtedness and surrender charges, and less any dividend value. The term "paid-up addition value" is defined as the cash value of additional insurance purchased with policy dividends. The term "dividend value" is defined as the total cash value of all policy dividends left on deposit with the company to accumulate at interest.

PART B

The information to be disclosed in Part B of Form OIR-D0-1180 (AGLC120Z8C) shall apply to the proposed additional insurance contract(s) being funded by policy values in a current, in-force policy. For purpose of this form, "proposed premium amount" is defined as any recurring payment which is planned for or which is required to be paid under the proposed policy.

PART C

The information to be disclosed in Part C of Form OIR-D0-1180 (AGLC120Z8C) shall apply to the current, in-force policy, and shall indicate the manner in which the policy values are being used to fund the purchase of the proposed policy. Part C is not to be completed if the current policy is totally surrendered. However, in the event of a total surrender of the current policy, Part A, B, D and the signature block of this form must still be completed.

When completing Part C of the form, each and every source of funding for the proposed policy must be identified, i.e., whether a policy loan, partial surrender, or dividend withdrawal or any combination there-of is being utilized. If more than one source of funding will be utilized to fund the initial and/or future premiums for the proposed policy, all applicable sections of Part C shall be completed.

For purposes of this form, a "partial surrender" is defined as any amount taken from the value of the current policy which is less than the total cash value available under such policy. The term "mode" is defined as the frequency upon which a policy loan, partial surrender or dividend withdrawal will be taken from the value of the current policy. In the event of a single loan, surrender or withdrawal, the words "one time only" shall be entered in the space provided. The term "loan interest rate" is defined as the rate of interest in effect on the date that this form is completed, as specified in the current policy contract.

PART D

The information to be disclosed in Part D of Form OIR-D0-1180 (AGLC120Z8C) shall apply to the current, in-force policy and the proposed additional policy, respectively.

SIGNATURES

In order to evidence that the required disclosure has been made, Form OIR-D0-1180 (AGLC120Z8C) shall be signed and dated by the soliciting agent or by a Corporate Officer, as well as the policyowner. For identification purposes, the agent or Corporate Officer shall enter his or her Florida License Number or Corporate title, respectively, in the space provided.

AIG

Bank Draft Authorization

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water Street, New York, NY 10038

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

How Automatic Bank Draft Works: Automatic bank draft is a debit service that offers a convenient way to pay insurance premiums. The Company will collect the insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Policy Number, if available	Name of Insured Applicant	Policy Number, if available	Name of Insured Applicant

PAYMENT OPTIONS: **Please select ONLY one payment option:**

☐ Draft Initial Premium and Draft Subsequent Premiums

Initial Premium: $_______.__ ☐ At Issue ☐ At Submit (Not available for all products or Employer Sponsored Plans)

- Initial premium at issue will be drafted at the time each policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.
- Initial premium will be drafted at Submit for those policies that qualify for this option. Additional initial premium due will be drafted at the time the policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.

Subsequent Premiums, if different: $_______.__

☒ Draft Only Subsequent Premiums

Check/Complete one of the following for Initial Premium payment:

☐ Check submitted with application in the amount of $_______.__.
☒ Check submitted on delivery.

DRAFT DETAILS: **Please provide the requested details.**

Preferred Withdrawal Date (1st-28th) __________ **Please debit my account for all outstanding premiums due.**

If a preferred withdrawal date is chosen and draft at issue is selected, we will draft subsequent premiums on this date.

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

Financial Institution Name ____________________

Financial Institution Address __________ City, State __________ ZIP ______

Type of Account: ☐ Checking ☐ Savings

Routing Number _________ (For checking account draft use routing # listed on check)

Account Number _________________ (DO NOT use credit/debit card)

Bank Account Owner(s): (For business accounts, list Business and Authorized Signer Name)

Name 1 First Name (Please Print) __________ Last Name __________

Email Address 1 __________

Date of Birth 1 (MM-DD-YYYY) __/__/____ SSN1 / TIN 1 _________

Name 2 First Name (Please Print) __________ Last Name __________

Email Address 2 __________

Date of Birth 2 (MM-DD-YYYY) __/__/____ SSN1 / TIN 2 _________

Bank Account Owner's Address: (For business accounts, list Business Address)

Street __________ City __________ State _____ ZIP ______

AGREEMENT:

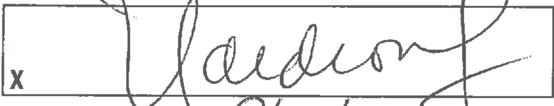
I (we) hereby authorize and request the Company or its representative to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the contract(s) listed, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s) even if such debits differ in amount from those specified in this form. I (we) hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason of dishonor of any debit or otherwise related to this authorization.

I (we) understand that this Authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable non-forfeiture provision. I acknowledge that notice of premiums due shall be waived and that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment in its Service Center.

I (we) authorize the Company to obtain information and/or reports from a consumer reporting agency or other company(ies) in order to verify, validate and/or authenticate the information and answers presented on this form. Any information gathered may be disclosed to any person or entity required to receive such information by law or as I may further consent.

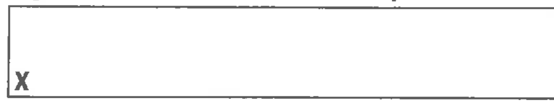
I (we) agree that this Authorization may be terminated by me or the Company at any time and for any reason by providing thirty (30) days' written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This request must be dated and all required signatures must be written in ink, using full legal names. This request must be dated and signed by the Bank Account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

Signature of Bank Account Owner



Date 9/15/20

Signature of Bank Account Owner, if joint account



Date ______

Please attach voided check for checking account draft or deposit slip for savings account draft.

QoL Advantage Form

Policy # (if known): ____________

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

First Name	MI	Last Name	Date of Birth	Social Security #
Nelly	_	Calderon Medina	12/27/57	770-34-4987

All related policies must have the same Insured, same Owner, same Bank Draft and must be applied for at the same time.

Policy 1: Permanent or Longest-Duration Term Policy For QoL Advantage Premium Discount Program (Enter UL/GUL/IUL policy or, if none, longest-duration term policy)

Name of Proposed Insured ____________
Plan ____________
Application Date ____________ Policy number, if known ____________

Other Related Polices

Policy 2: Name of Proposed Insured ____________
Plan ____________
Application Date ____________ Policy number, if known ____________

Policy 3: Name of Proposed Insured ____________
Plan ____________
Application Date ____________ Policy number, if known ____________

Policy 4: Name of Proposed Insured ____________
Plan ____________
Application Date ____________ Policy number, if known ____________

Policy 5: Name of Proposed Insured ____________
Plan ____________
Application Date ____________ Policy number, if known ____________

Policy 6: Name of Proposed Insured ____________
Plan ____________
Application Date ____________ Policy number, if known ____________

Agent Agreement and Signature

I certify that the above information is true and complete to the best of my knowledge and belief.

Writing Agent Name (Please print) Mayte Carratala Date 9/15/20
Writing Agent Name Signature [signature]
State License # W473391 Phone # 800-325-8907
Email mzamora@seemanholtz.com Fax # ____________

AGLC108225-2015 Rev0217

Limited Temporary Life Insurance Agreement (Agreement)

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW. SUCH INSURANCE IS NOT AVAILABLE FOR ANY RIDERS OR ACCIDENT AND/OR HEALTH INSURANCE. PLEASE FOLLOW STEPS 1 - 4.

1. Check appropriate Company:

☐ American General Life Insurance Company, Houston, TX
☐ The United States Life Insurance Company in the City of New York, New York, NY

In this Agreement, "Company" refers to the insurance company whose name is checked above, which is responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments. In this Agreement, "Policy" refers to the Policy or Certificate applied for in the application. In this Agreement, "Proposed Insured(s)" refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable.

2. Complete the following: *(please print)*

Primary Proposed Insured ____________________
Other Proposed Insured ____________________
(applicable only for a joint life or survivorship policy)
Owner *(if other than Primary Proposed Insured)* ____________________
Modal Premium Amount Received ____________________
Date of Policy Application ____________________

3. Answer the following questions:

Question	Yes	No
a. Has any Proposed Insured ever been diagnosed with or sought treatment from a member of the medical profession for any of the following: a heart attack; stroke; coronary artery disease or other heart disease; cancer; diabetes; or disorder of the immune system, (excluding AIDS, ARC and HIV)?	☐	☒
b. Has any Proposed Insured ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☒
c. Has any Proposed Insured, during the last two years: (1) been confined in a hospital or other health care facility (except for childbirth without complications); (2) received medical treatment or counseling for alcohol or drug use from a member of the medical profession or a substance abuse counselor; or (3) been advised by a member of the medical profession to have any diagnostic test or surgery not yet performed?	☐	☒
d. Is any Proposed Insured either less than 14 days old or over age 70 1/2?	☐	☒

STOP If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under this Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under this Agreement.

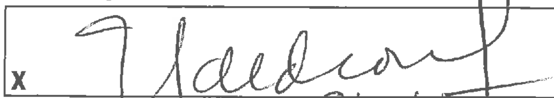
4. Complete and sign this section:

Any misrepresentation contained in this Agreement and relied on by the Company may be used to deny a claim or to void this Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of this Agreement.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I, the Owner, have received a copy of this two-page Agreement and read it or have had it read to me and agree to be bound by the terms and conditions stated herein on the following page.

Owner Signature



X

Owner signed on (date) 9/15/20

Primary Proposed Insured (PPI) Signature (if other than Owner)

X

(If under age 16, signature of parent or Guardian)

PPI signed on (date) ____________________

Other Proposed Insured (OPI) Signature (if other than Owner)

X

(If under age 16 and coverage exceeds $150,000, signature of both parents required)

OPI signed on (date) ____________________

Writing Agent Name (please print) Mayte Carratala

State License # W473391

Agent Instructions: Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.

TERMS AND CONDITIONS OF COVERAGE UNDER THIS AGREEMENT

A. **Eligibility for Coverage:** If the correct answer is YES to any of the questions listed above, temporary insurance is NOT available and this Agreement is void.

Agents do not have authority to waive these requirements or to collect premium by any means including cash, check, bank draft authorization, credit card authorization, salary savings, government allotment, payroll deduction or any other monetary instrument if any Proposed Insured is ineligible for coverage under this Agreement.

B. **When Coverage Will Begin:**
COVERAGE WILL BEGIN WHEN ALL OF THE FOLLOWING CONDITIONS HAVE BEEN MET:

- Part A of the application must be completed, signed and dated; and
- The first modal premium must be paid; and
- Part B of the application must be completed, signed and dated and all medical exam requirements satisfied.

Coverage under this Agreement will not exist until all of the conditions listed above have been met.

The first modal premium will be considered paid, if one of the following valid items is submitted with Part A of the application and that payment is honored: (i) a check in the amount of the first modal premium; (ii) a completed and signed Bank Draft Authorization; (iii) a completed and signed Credit Card Authorization form; (iv) a completed and signed salary savings authorization; (v) a completed and signed government allotment authorization; (vi) a completed and signed payroll deduction authorization. Temporary life insurance under this Agreement will not begin if any form of payment submitted is not honored. All premium payments must be made payable to the Company checked above. Do not leave payee blank or make payable to the agent. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued, or refunded if the Company declines the application or if the policy is not accepted by the Owner.

C. **When Coverage Will End:**
COVERAGE UNDER THIS AGREEMENT WILL **END** at 12:01 A.M. ON THE **EARLIEST** OF THE FOLLOWING DATES:

- The date the policy is delivered to the Owner or his/her agent and all amendments and delivery requirements have been completed;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Company;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it has declined or cancelled the application;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that the application will not be considered on a prepaid basis;
- The date the Company mails or otherwise provides a premium refund to the Owner or his/her agent; or
- [60]calendar days from the date coverage begins under this Agreement.

D. The Company will pay the death benefit amount described below to the beneficiary named in the application if:
- The Company receives due proof of death that the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) died, while the coverage under this Agreement was in effect, except due to suicide; and
- All eligibility requirements and conditions for coverage under this Agreement have been met.

The total death benefit amount pursuant to this Agreement and any other limited temporary life insurance agreements covering the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) will be the **lesser** of:

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- $1,000,000 plus the amount of any premium paid for coverage in excess of $1,000,000 ; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

Agent Instructions: Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.

LEAVE THIS FORM WITH THE PROPOSED INSURED(S)

NOTICES TO THE PROPOSED INSURED(S)

American General Life Insurance Company, Houston, TX

The United States Life Insurance Company in the City of New York, New York, NY

You have applied for life insurance with one of the insurance companies identified above ("Company"). This notice is provided on behalf of that Company.

FAIR CREDIT REPORTING ACT

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

P.O. Box 1931
Houston, TX 77251-1931

Upon receipt of such a request, the Company will respond by mail within five business days.

MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices you should direct your requests to the Company at: P.O. Box 1931, Houston, TX 77251-1931

TELEPHONE INTERVIEW INFORMATION

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

USA PATRIOT ACT (This notice is printed in compliance with Section 326 of the USA Patriot Act)

IMPORTANT INFORMATION ABOUT PROCEDURES FOR APPLYING FOR AN INSURANCE POLICY OR ANNUITY CONTRACT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions, including insurance companies, to obtain, verify, and record information that identifies each person who opens an account, including an application for an insurance policy or annuity contract.

What this means for you: When you apply for an insurance policy or annuity contract, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Supplemental Application for Chronic Illness Accelerated Death Benefit Rider Florida Version

American General Life Insurance Company, Houston, TX

This is a supplement to the application for the Life Insurance for the Primary Proposed Insured. Please complete if the Chronic Illness Accelerated Death Benefit Rider is being elected.

(Check the box that applies)

☐ New Application ☐ Reinstatement ☐ Base Policy Specified Amount Increase

1. Primary Proposed Insured

First Name Nelly MI ___ Last Name Calderon Medina Date of Birth 12/27/57

2. Benefits (Complete for New Application Only)

A. Maximum Monthly Benefit: ☐ **2% of Lifetime Maximum Benefit** ☒ **4% of Lifetime Maximum Benefit** ☐ **Maximum Per Diem Allowable**

B. Lifetime Maximum Benefit Percentage: ________%

Note: If the Chronic Illness Accelerated Death Benefit Rider is approved and added to your policy, the policy will also include, at no additional charge, a Terminal Illness Accelerated Death Benefit Rider. The Disclosure of Accelerated Death Benefits form must be completed for the Chronic Illness Accelerated Death Benefit rider, if required by the state of issue.

3. Health Questions – In this section, "you" refers to the Primary Proposed Insured.

A. During the last 12 months, have you:

1. Required assistance or supervision of any kind to perform an activity of daily living, such as mobility (including the use of a pronged cane), taking medications, dressing, eating, walking, bathing or toileting? ☐ Yes ☒ No
2. Used a catheter, chair lift, dialysis, motorized scooter, oxygen equipment, quad or three-pronged cane, respirator, walker, or wheelchair? ☐ Yes ☒ No
3. Been advised by a licensed member of the medical profession to enter or reside in a nursing home, assisted living facility, long term care facility, Continuing Care Retirement Community (CCRC), residential care facility, rehabilitation facility, Skilled Nursing Facility (SNF) or an adult day care, or required home health care? ☐ Yes ☒ No

B. During the last 3 years, have you used insulin to treat Diabetes? ☐ Yes ☒ No

Have you ever been diagnosed or treated by a licensed health care provider for:

1. Diabetes WITH COMPLICATIONS (such as eye, kidney, or nerve damage)? ☐ Yes ☒ No
2. Diabetes AND Heart Disease, Stroke, or Peripheral Vascular Disease? ☐ Yes ☒ No

C. Have you EVER been diagnosed with, been treated for, tested positive for, or received medical advice from a licensed health care provider for any of the following conditions:

1. Alzheimer's disease, Dementia, Mild Cognitive Impairment (MCI), or Organic Brain Syndrome (OBS) ☐ Yes ☒ No
2. Amputation due to disease ☐ Yes ☒ No
3. ALS (Lou Gehrig's disease) ☐ Yes ☒ No
4. Stroke, Cerebral Vascular Accident (CVA), or Transient Ischemic Attack (TIA) ☐ Yes ☒ No
5. Organ Transplant (other than corneal) ☐ Yes ☒ No
6. Multiple Sclerosis ☐ Yes ☒ No
7. Huntington's Chorea ☐ Yes ☒ No
8. Muscular Dystrophy ☐ Yes ☒ No
9. Myasthenia Gravis ☐ Yes ☒ No
10. Macular Degeneration ☐ Yes ☒ No
11. Blindness ☐ Yes ☒ No
12. Optic Neuritis ☐ Yes ☒ No

13. Osteoporosis with fractures ☐ Yes ☒ No
14. Parkinson's disease ☐ Yes ☒ No
15. Post-Polio Paralytic Syndrome ☐ Yes ☒ No
16. Polymyositis ☐ Yes ☒ No
17. Scleroderma ☐ Yes ☒ No
18. Memory loss ☐ Yes ☒ No
19. Unplanned weight loss greater than 15 pounds within the last 2 years ☐ Yes ☒ No
20. Arthritis with narcotic pain medication within the past 12 months ☐ Yes ☒ No

D. To the best of your knowledge and belief, do you have a parent or sibling diagnosed or treated by a licensed health care provider for Huntington's chorea or Polycystic Kidney Disease? ☐ Yes ☒ No

If any question in 3. A-D was answered yes, the rider is not available for the Primary Proposed Insured and this supplemental application should not be completed or submitted.

E. In the last 5 years, have you been diagnosed with, treated for, tested positive for, or received medical advice from a licensed health care provider for any of the following conditions:

1. Disorientation ☐ Yes ☒ No
2. Multiple falls or injury due to a fall ☐ Yes ☒ No
3. Chest Pain ☐ Yes ☒ No
4. Loss of balance ☐ Yes ☒ No
5. Loss of strength ☐ Yes ☒ No
6. Tremors ☐ Yes ☒ No
7. Dizziness ☐ Yes ☒ No

F. Do you have a handicap sticker, handicap placard, or handicap license plate? (If yes, give reason below) ☐ Yes ☒ No

G. In the last 24 months, have you had to limit or been advised by a licensed health care provider to limit, reduce, discontinue or restrict any activities or hobbies? (If yes, give reason below) ☐ Yes ☒ No

H. In the past 24 months, have you required assistance with shopping, arranging transportation, housekeeping, cooking, laundry, meal preparation, managing finances, managing medications, using the telephone or used a straight cane? (If yes, give reason below) ☐ Yes ☒ No

Give details to all yes answers to questions 3. E-H.

Question #	Nature of Condition/Date of diagnosis	Date of last treatment or last medication taken	Name & address of Physician seen

I. Within the past 5 years, have you received any long term care benefits, disability income benefits or Social Security Disability Income Benefits? (If yes, please provide details in **Section 4, Remarks.**) ☐ Yes ☒ No

J. Within the past 5 years, have you been declined for long term care insurance, including long term care or chronic illness insurance provided by rider to a life insurance or other policy including annuities? (If yes, please provide the name of the company, date and the reason in **Section 4, Remarks.**) ☐ Yes ☒ No

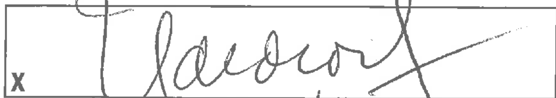
4. Remarks

I, the Primary Proposed Insured signing below, agree that I have read the statements contained in this application supplement and that all statements and answers given in this application supplement are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within the contestable period.

I understand that benefits under the Chronic Illness and Terminal Illness riders are provided through an accelerated death benefit option, and that if I exercise the accelerated benefit option, any beneficiary I designate will receive a reduced death benefit.

Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Primary Proposed Insured Signature



X

Date 9/15/20

Licensed Writing Agent

X

Date 9/15/20.

Writing Agent Name Mayte Carratala

Writing Agent Number 533641

Agency Number 52999